NOTICE OF INDEPENDENT REVIEW DECISION

May 10, 2002

Requestor

Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0542-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The _____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to _____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 26 year old female sustained a low back injury on ___ when a shelf she was working on fell on her. The patient underwent a discogram in January of 2002 that reportedly reproduced her symptoms at L5-S1 levels. A CT scan done post-operatively was normal except for the changes created by the discogram. The patient continues to complain of sharp pain in the midlumbar area of her back with radiation to both the right and left flank areas then down to the right hip as well as pain involving the entire right thigh, right calf and right foot.

Requested Service(s)

L5-S1 annuloplasty with fluoroscopy and sedation

Decision

It is determined that the annuloplasty with fluoroscopy and sedation are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is a lack of objective evidence to implicate a disc problem. Despite a subjective report of "concordant" pain when L5-S1 disc was injected with dye, a subsequent CT scan objectively demonstrated no annular tear or abnormal disc morphology. Moreover, the patient has alternating pain into either or both legs. She is not a candidate for either Intradiscal Electrothermal Annuloplasty (IDET) or Radio Frequency Annuloplasty (RFA) based on morphologically normal disc and non-physiologic radicular pain complaints. RFA is also an inferior procedure compared to IDET, without long-term efficacy studies to justify its use. It (RFA) does not produce subsequent tissue heating and heats only a limited area.

Appropriate management of this patient's condition would include non-steroidal anti-inflammatory agents, simple analgesics, skeletal muscle relaxants, back rehabilitation program, and physical modalities (including heat and cold).

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code '148.3). This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code '102.4(h) or 102.5(d)). A request for hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this _____day of _____2002.

Signature of IRO Employee:

Printed Name of IRO Employee: